Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2440-01

MFDR Date Received
March 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The worker's compensation carrier has issued a response to our facilities request for reconsideration which reads; procedure code invalid at time of service. Clearly all of our facilities documentation has been attached since initial faxing. Upon further review this documentation does indeed support the level of service billed. Invalid procedure code is also very vague and does not necessarily provide our facility with a proper avenue for collection."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier did not reimburse the $350.00 billed for the above date of service as the health care provider used an incorrect CPT code (99455 V4) as explained in the EOB. Dr. Shahid Syed, the physician that did the impairment rating evaluation, was not the treating doctor. He did the examination on behalf of the treating doctor. The proper CPT code is 99456 which generates the $350.00 reimbursement per DWC Rule 134.204 (j) (3) (c). If Allied Medical Centers will resubmit the bill with CPT code 99456, the carrier will pay the $350.00 charge."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2010	99455-V4	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for workers' compensation specific codes, services and programs provided in the Texas workers' compensation.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 181 – Payment adjusted because this procedure code was invalid on the date of service
   - 1 – This charge will be re-evaluated upon receipt of the proper procedure codes or procedure code/modifier combination as listed in the fee schedule
   - * – Previously requested information/documentation has not been received

Issues

1. Did the requestor document the service billed?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT code 99455-V4 rendered on October 15, 2010.
2. Per 28 Texas Administrative Code §134.204 "(3) The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."
   - Review of box 31 of the CMS-1500 documents that the provider of service is Shahid H. Syed, M.D. Review of box 17 of the CMS-1500 documents the name of the referring provider or other source as Shahid H. Syed, M.D.
   - Review of the submitted documentation titled, *Report of Medical Evaluation* dated October 15, 2010 indicates in the report that injured employee was referred by Dr. Reuben, the treating doctor of record with the division.
3. Per 28 Texas Administrative Code §134.204 "(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has: (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or, (ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350..."
   - The requestor did not submit documentation to support that the injured employee had been previously treated by Dr. Shahid H. Syed, therefore CPT code 99455 was billed in error.
4. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 99455-V4.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.